Nationwide Life Insurance Company
Home Office: Columbus, Ohio

On Your Side®

Commonwealth of Kentucky Employee Group Life Insurance Program Enrollment/Change/Termination Form

Group Insurance Contract : 90002

Please do not staple or attach other documents to this form. Please complete and print all information. Use black or blue ink only.

SSN		Location Name (Specify name of Agency, School Board or Health Dept.)	
Name (Last, First, MI)		Location Number	Birthdate
Address (Street Name/Number)	Annual Salary	Hire Date	Gender ☐ Male ☐ Female
(City, County, State, Zip)	Work Number	Home Number	

A. Basic Life and Accidental Death and Dismemberment (AD&D) Insurance

Eligible employees are insured at no cost to the employee for Basic Life and AD&D Insurance
ALL ELIGIBLE EMPLOYEES $20,000 Cost: (employer paid)

B. Optional Life and Accidental Death and Dismemberment (AD&D) Insurance (Select One Plan)

I wish to ___enroll* in, ___change* to, ___terminate the optional insurance plan checked below:

☐ Plan 1 $5,000	☐ Plan 2 $10,000	MONTHLY CONTRIBUTION AGE BAND — RATE PER $1,000 Under 40 — $0.25 40 — 59 — $0.57 60 and over — $0.90
☐ Plan 3 100% of annual earnings**	☐ Plan 4 200% of annual earnings**	

* Evidence of insurability may be required depending on the circumstances and/or for Insurance over $150,000.
** Under plans 3 and 4, Insurance amounts will be rounded to the nearest multiple of $1,000. Amounts of insurance do not automatically increase with an earnings change.

C. Dependent Life Insurance (Select One Plan)

Please ___ enroll* my dependents in, ___ change* my present plan to, or ___ terminate the plan checked below:

	☐ Plan A	☐ Plan B	☐ Plan C	☐ Plan D	☐ Plan E
Spouse**	$10,000	$ 5,000	$ 5,000	$10,000	--
Dependent Children to 6 mos	$ 2,500	$ 1,500	--	--	$ 2,500
Dependent Children 6 mos to 18 yrs***	$ 5,000	$ 3,000	--	--	$ 5,000
MONTHLY CONTRIBUTION	$ 10.90	$ 5.90	$ 2.50	$ 8.70	$ 3.60

* Evidence of insurability may be required depending on circumstances
** Spouse means a person to whom you are legally married
*** 18 and older if attending an educational institution and relying on the employee for financial support

D. Waiver of Optional Life and Dependents Coverage

☐ I certify that I have been given the opportunity to enroll myself and my eligible dependents in the above coverage. I have declined the Optional and/or Dependents Life coverage and understand that it will be necessary for me and my dependents to furnish evidence of insurability if I desire any of the above coverage in the future (other than during an open enrollment period or other exception detailed in the certificate booklet).

E. Fraud Warning: Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person, or knowing that he is facilitating commission of a fraud, submits incomplete, false, fraudulent, deceptive or misleading facts or information when filing an insurance application or a statement of claim for payment of a loss or benefit commits a fraudulent insurance act, is/may be guilty of a crime and may be prosecuted and punished under state law. Penalties may include fines, civil damages and criminal penalties, including confinement in prison. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant or if the applicant conceals, for the purpose of misleading, information concerning any fact material thereto.

F. Employee Signature and Date (Required)

Employee Signature _____ Date _____

To Be Completed by the Insurance Coordinator

IC Signature _____ Date _____
Phone Number _____ Location # _____
Employment Hire Date _____
Employment Termination Date _____
Date of Qualifying Event _____
Description of Qualifying Event _____

Send *PERSONNEL CABINET COPY TO:*

Personnel Cabinet
Group Life Insurance Administration
501 High Street, 3rd Floor
Frankfort, KY 40601

NSHAPP 2800 CWKY
PERSONNEL COPY – WHITE

COORDINATOR COPY – YELLOW

SEE BACK OF PINK FORM FOR INSTRUCTIONS
EMPLOYEE COPY - PINK

Instructions

- Please print all information. All information should be filled in with black or blue ink only.
- Please do not staple or attach other documents to the enrollment form.
- An enrollment form will be required for all employees for initial setup if the employee only wants the basic coverage.
- Location name and number should be completed.
- Annual earnings are required when selecting Optional Plan 3 or 4.
- Only one plan may be selected for Optional Term Life Insurance coverage.
- Only one plan may be selected for Dependent Term Life Insurance coverage.
- For coverage over $150,000 an evidence of insurability form has to be completed and approved by the insurance carrier before coverage can be set up.
- Spouse means a person to whom you are legally married.
- Child 18 or older can remain covered providing the child is a full-time student and relying on the employee for financial support.
- Signature and date required by the employee.
- Insurance Coordinator *should verify all information* and sign and date form.
- Description of Qualifying Event should be completed by the Insurance Coordinator. For example, leave without pay, military leave, birth of a child, marriage, transfer, earning increment, termination of employment or death.
- Date of Qualifying Event should be listed as the last day employee worked or official date of termination, not when the insurance will end.
- The original should be submitted to the Personnel Cabinet, Group Life Insurance Branch.
- Premium rates are current as of January 1, 2010. Rates may change as the insured enters a higher age category or if the plan experience requires a change for all insureds.